

Department of Health and Human Services
Health Care Financing AdministrationForm Approved
OMB No. 0938-0086**DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT****I. Identifying Information**

(a) Name of Entity Life Care Centers of America, Inc.	D/B/A Cherry Hill Manor	Provider No. 699 41-5053	Vendor No.	Telephone No. (401) 231-3102
Street Address 2 Cherry Hill Road		City, County, State Johnston, Providence, RI		Zip Code 02919

(b) (To be completed by HCFA Regional Office) Chain Affiliate No. ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ LB1

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

- A Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

☐ Yes ☒ No LB2

- B Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

☐ Yes ☒ No LB3

- C Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

☐ Yes ☒ No LB4

- III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on Page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks

Name	Address	EIN
Forrest L. Preston	3570 Keith Street, NW, Cleveland, Tennessee 37312	[REDACTED] 5
100% Sole Shareholder		

LB5

- (b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☒ Corporation ☐ Unincorporated Associations ☐ Other (Specify)

LB6

- (c) If the disclosing entity is a corporation, list names, addresses of the Directors and EINs for corporations under Remarks
Please See Attached Exhibit "O".

Check appropriate box for each of the following questions

- (d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example, sole proprietor partnership or members of Board of Directors) If yes, list names addresses of individuals and provider numbers

☒ Yes ☐ No LB7

Name	Address	Provider Number
Please See Attached Exhibits.		

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IV (a)	Has there been a change in ownership or control within the last year? If yes, give date _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB8
(b)	Do you anticipate any change of ownership or control within the year? If yes, when? _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB9
(c)	Do you anticipate filing for bankruptcy within the year? If yes, when? _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB10
V	Is this facility operated by a management company or leased in whole or part by another organization? If yes, give date of change in operations <u>Lease 08/31/2000.</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB11
VI	Has there been a change in Administrator Director of Nursing or Medical Director within the last year?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB12
VII (a)	Is this facility chain affiliated? (If yes list name, address of Corporation, and EIN) Name <u>Life Care Centers of America, Inc.</u> Address <u>3570 Keith Street, NW</u> <u>Cleveland, Tennessee 37312</u> EIN # <u>62-0963862</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB13
VII (b)	If the answer to Question VII.a. is No, was the facility ever affiliated with a chain? (If YES list Name, Address of Corporation and EIN) Name _____ EIN # <u>N/A</u> Address _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	LB14 LB18
VIII	Have you increased your bed capacity by 10% or more or by 10 beds, whichever is greater, within the last 2 years? If yes, give year of change _____ Current beds _____ Prior beds _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB15 LB16 LB17

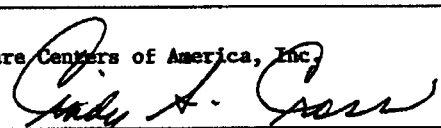
WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed) Cindy S. Cross	Title Assistant Secretary
Signature <i>Cindy S. Cross</i> By: <i>Cindy S. Cross</i>	Date 04/04/2002
Remarks	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESForm Approved
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(b) Do you anticipate any change of ownership or control within the year? If yes, when? _____		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB9
(c) Do you anticipate filing for bankruptcy within the year? If yes, when? _____		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB10
V. Is this facility operated by a management company, or leased in whole or part by another organization? If yes, give date of change in operations <u>Lease - 8/31/00</u>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB11
VI Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? <u>Administrator - May, 2003; Director of Nursing - May, 2003</u>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB12
VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN) Name <u>Life Care Centers of America, Inc.</u> EIN # <u>62-0963862</u>		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB13
Address <u>3570 Keith Street, NW</u> <u>Cleveland, TN 37312</u>			LB14
VII. (b) If the answer to Question VII.a. is No was the facility ever affiliated with a chain? (If yes, list Name Address of Corporation, and EIN) Name _____ EIN # <u>N/A</u>		<input type="checkbox"/> Yes <input type="checkbox"/> No	LB18
Address _____			LB19
VIII Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? If yes, give year of change _____		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB15
Current beds _____ LB16 Prior beds _____ LB17			

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Name of Authorized Representative (Typed) Cindy S. Cross		Title Assistant Secretary
Signature Life Care Centers of America, Inc. By: 		Date 6/30/03
Remarks		

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DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information				
(a) Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Life Care Centers of America, Inc.	Cherry Hill Manor	Medicare 41-5053 Medicaid 00699		(401)231-3102
Street Address		City County State		Zip Code
2 Cherry Hill Road		Johnston, Providence, RI		02919
(b) (To be completed by CMS Regional Office)		Chain Affiliate No.		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> LB1

II Answer the following questions by checking "Yes" or "No." If any of the questions are answered "Yes," list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

(a) Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by titles XVIII, XIX, or XX?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB2
(b) Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX, or XX?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB3
(c) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	LB4

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Name	Address	EIN
Forrest L. Preston	3570 Keith Street NW, Cleveland, Tennessee 37312	[REDACTED]
100% Sole Shareholder		

(b) Type of Entity:	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Partnership	<input checked="" type="checkbox"/> Corporation	LB6
	<input type="checkbox"/> Unincorporated Associations	<input type="checkbox"/> Other (Specify)		
(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks. Please see attached Exhibit "O".				

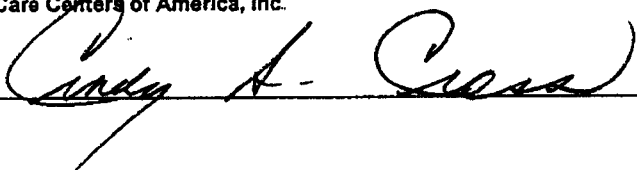
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 (d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	LB7
Name	Address	Provider Number
Please see attached Exhibits		

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VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? Administrator 09-08-03; Director of Nursing 10-15-04		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB12
VII. (a) Is this facility chain affiliated? (If yes, list name address of Corporation, and EIN) Name _____ EIN # _____ Life Care Centers of America, Inc 62-0963862 Address _____ 3570 Keith Street NW Cleveland, TN 37312		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	LB13 LB14
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Name of Authorized Representative (Typed) Cindy S. Cross		Title Assistant Secretary
Signature <u>Life Care Centers of America, Inc.</u> By: 		Date April 21, 2004
Remarks		